

Harvard Pilgrim Health Care, Inc. The Harvard Pilgrim Tiered Copayment HMO - City of Newton

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7/1/2013 — 6/30/2014

Coverage for: Individual + Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.harvardpilgrim.org** or by calling **1-888-333-4742**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	\$250 per member per Plan Year / \$500 per family per Plan Year The deductible applies to benefits cited in the chart starting on Page 3, for other benefits see your Plan document.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$1,000 per member per Plan Year / \$2,500 per family per Plan Year	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Please see your Schedule of Benefits for out-of-pocket maximum exclusions for your plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers , see www.harvardpilgrim.org or call 1-888-333-4742 .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 3 for how this plan pays different kinds of providers .

Questions: Call 1-888-333-4742 or visit us at **www.harvardpilgrim.org**. If you are not clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.harvardpilgrim.org/fhcr** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why this matters:
Do I need a referral to see a specialist?	Yes, some exceptions apply.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services .



- Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you visit a health care provider's office	Primary care visit to treat an injury or illness	Copayment Level 1: \$20 Copayment per visit	None
or clinic	Specialist visit	Copayment Level 1: \$20 Copayment per visit Copayment Level 2: \$35 Copayment per visit	Copayment Level 1 services are generally services of primary care providers. Copayment Level 2 services are generally specialists.
	Other practitioner office visit	Deductible, then no charge	Cost sharing may vary for certain practitioners.
	Preventive care/ screening/ immunization	No charge	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then no charge	None
	Imaging (CT/PET scans, MRIs)	Deductible, then no charge	None

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information	Most generic drugs	Retail Pharmacy Tier 1: \$10 Copayment Mail Order Pharmacy Tier 1: \$20 Copayment	 Retail Pharmacy – limited to 30 day supply per refill Mail Order Pharmacy – limited to 90 day supply per refill
about prescription drug coverage is available at www.	Preferred brand drugs	Retail Pharmacy Tier 2: \$25 Copayment Mail Order Pharmacy Tier 2: \$50 Copayment	Same as above.
harvardpilgrim.org.	Non-preferred brand drugs	Retail Pharmacy Tier 3: \$45 Copayment Mail Order Pharmacy Tier 3: \$90 Copayment	Some generic drugs are in this tier. Same as above.
	Specialty drugs	All drugs are covered in Retail and Mail Order Pharmacy Tiers 1 — 3	Must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then no charge	None
	Physician/surgeon fees	Deductible, then no charge	None
If you need immediate medical attention	Emergency Room Services	\$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	None
	Emergency Medical Transportation	Deductible, then no charge	None
	Urgent Care	Copayment Level 1: \$20 Copayment per visit Copayment Level 2: \$35 Copayment per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then no charge	None
	Physician/surgeon fee	Deductible, then no charge	None

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible, then no charge	None
	Mental/Behavioral health inpatient services	Group Therapy: \$10 Copayment per visit Individual Therapy: \$20 Copayment per visit	None
	Substance use disorder outpatient services	Deductible, then no charge	None
	Substance use disorder inpatient services	Group Therapy: \$10 Copayment per visit Individual Therapy: \$20 Copayment per visit	None
If you are pregnant	Prenatal and postnatal care	No charge	None
	Delivery and all inpatient services	Deductible, then no charge	None
If you need help	Home health care	Deductible, then no charge	None
recovering or have other special health needs	Rehabilitation services (Inpatient)	Deductible, then no charge	Limited to 100 days per Plan Year.
liccus	Habilitation services (Outpatient)	Deductible, then no charge	 Occupational Therapy - limited to 90 consecutive days per condition per Plan Year. Physical Therapy - limited to 90 consecutive days per condition per Plan Year.
	Skilled nursing care	Deductible, then no charge	Limited to 100 days per Plan Year.
	Durable medical equipment	Deductible, then no charge	– Wigs – limited to \$350 per Plan year.
	Hospice service	Deductible, then no charge	If inpatient services are required, please see "If you have a hospital stay".

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Copayment Level 1: \$20 Copayment per visit	Limited to 1 exam per Plan Year. You may have other coverage under a Vision Rider.
	Glasses	Not covered	You may have other coverage under a Vision Rider.
	Dental check-up - Up to the age of 13.	Copayment Level 1: \$20 Copayment per visit	Limited to 2 exams per Plan Year. You may have other coverage under a Dental Rider.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acpuncture
- Chiropractic Care
- Hearing Aids
- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Most Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Infertility Treatments
- Routine eye care (Adult)

OR

Your Rights to Continue Coverage:

Individual health insurance sample-

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1–800–333–4742. You may also contact your state insurance department at:

Group health coverage sample-

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1–800–333–4742. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HPHC Member Appeals Member Services Department Harvard Pilgrim Health Care, Inc. 1600 Crown Colony Drive Quincy, MA 02169

Telephone: 1-888-333-4742

Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration 1-866-444-3272 www.dol.gov/ebsa/healthreform Health Care for All 30 Winter Street, Suite 1004 Boston, MA 02108 1-800-272-4232 http://www.hcfama.org/helpline

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different **plans**.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

■ Amount owed to providers: \$7,540

Plan pays: \$7,120Patient pays: \$420

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

1 3	
Deductibles	\$250
Co-pays	\$20
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$420

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ Amount owed to providers: \$5,400

Plan pays: \$3,540Patient pays: \$1,860

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$140
Co-pays	\$1,640
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,860

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

X No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

X No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.